Staking Your Claim with Health Insurers

Follow these pointers for submitting insurance claims and handling denials.

For many psychologists, the health of their practice finances is tied directly to the insurance claims process. Submitting and following up on claims is often time consuming and frustrating. This article offers pointers about submitting claims and handling denials that can help the process run more smoothly.

7 Pointers on Claims Submission

• Know the payer’s coverage policies such as pre-authorization requirements and restrictions on the number of hours that may be billed for a particular service. This is important whether you are dealing with a private sector insurance plan or a public program. Medicare Administrative Contractors have websites that contain these policies, as do many private insurance carriers.

• Use essential billing tools to help you code properly. Two of the most important billing tools are the CPT® procedure codes and the ICD-9-CM diagnosis codes. CPT code information is available through the American Medical Association’s (AMA) website, which includes a search function that allows a limited number of free online searches for code numbers and provides the Medicare payment rate for each code based on geographic area. Publications containing the CPT codes and the ICD-9-CM codes can be purchased through the AMA’s website: ama-assn.org. A CD-ROM version of the ICD-9-CM codes is also available online at the U.S. Government Printing Office Bookstore: bookstore.gpo.gov.

• Make sure that the entire claim form is completed accurately. For example, the patient’s name should match the way it appears on his or her Medicare or other insurance card.

• File claims promptly after delivering services. Doing so helps minimize the time between service delivery and reimbursement and is particularly important for your practice finances if your claim is rejected and must be re-filed. Further, preparing a claim when the details of a patient encounter are fresh in mind can help ensure accuracy.

• Consistently document patient encounters in the record, being sure to note start and stop times for timed services such as psychotherapy. From the carrier’s standpoint, if you don’t record a service, you didn’t provide it. Your documentation should reflect patient progress in light of his or her treatment plan.

• Bill only for time spent with the client. Descriptors for outpatient procedure codes used by psychologists include the phrase “face-to-face with the patient.” While other professional activities such as report preparation may be associated with a client interaction, such activities are considered part of the professional service and are included in the payment amount.

• Reflect the predominant service provided to the client/patient. Medicare and most private insurers will pay only for one service provided to a patient on any particular day. The predominant service typically reflects the amount of time spent on professional activity. For example, if a 50-minute visit with a patient after psychological testing involves 15 minutes of discussing test results followed by 35 minutes of providing psychotherapy related to the assess-
ment, you would bill the psychotherapy code 90806 rather than a psychological or neuropsychological testing code.

9 Tips for Handling Claims Denials

• **Thoroughly review all notifications regarding the claim such as an Explanation of Benefits.** The notification should indicate whether a claim was paid in full, partially paid, delayed or denied. If payment is denied, the notification should specify the reason(s) and outline the specific procedures and documentation required to resubmit the claim or file an appeal.

• **Make sure you understand what is being denied and why.** Is the company just asking for more information related to the claim, or is the company saying that a service is not “medically necessary” or otherwise ineligible for coverage? If the notification of denial is not clear, contact the insurance company for more information. In addition to eliciting a stated reason for the denial, you may find out that the claim was adjudicated incorrectly because of an administrative error.

• **Use a cordial approach at the outset.** The best approach to resolving problems with insurance companies often involves starting with a cordial phone call or email—especially when you have an established relationship with the insurance company representative—and becoming more assertive if your polite approach does not produce results. (See the sidebar at right for additional information about email communications.)

• **Learn about the company’s appeals process before filing an appeal.** When you know the company’s policies, you are better prepared to respond to its actions. Appeals procedures may vary by insurance company and state law. You should keep current information about the claims adjudication and appeals processes for each company with which you work. This information often appears on insurance company websites and may be provided if you sign a contract with a company. Make sure you know what information you need to submit if you decide to file an appeal.

• **Be persistent.** You may need to resubmit a claim or file an appeal more than once, but do not give up. Your persistence can demonstrate to the insurance company that you are serious about resolving the problem and getting paid.

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**BE MINDFUL OF HIPAA**

Exercising caution if you communicate via email. If you are not already complying with the Health Insurance Portability and Accountability Act (HIPAA), an email that includes patient information may trigger your need to comply—because it is likely to be deemed an electronic transmission of protected health information in connection with health insurance claims. Compliance includes performing the necessary risk analysis and risk management related to electronic communications as required by the HIPAA Security Rule.

Detailed information about the Security Rule is provided in “The HIPAA Security Rule Primer” from the APA Practice Organization, available online at bit.ly/hipaasecurity. Further, APAPO offers a “HIPAA Security Rule Online Compliance Workbook” at our Practice Central website that assists psychologists with risk analysis and management. This Continuing Education product is found in the Course Catalog at apapracticecentral.org/ce/courses/index.aspx.

• **Do not delay.** Submit and resubmit claims within the timeframe specified by the company and/or the applicable laws in your state. Otherwise, any requests for reconsideration or appeal may be denied as untimely and the claim may be adjudicated solely on the information you already provided.

• **Maintain records on disputed claims.** When you call an insurance company for more information about a claim or an appeal, keep a record of the information you are given, along with the date of the conversation and the name of the representative with whom you spoke. Store these notes with other key information about the claim, including any other actions your office took to follow up on the claim and the outcome of each action. These records can be important for future actions such as taking your appeal to higher levels.

• **Take advantage of available help.** The state insurance commissioner’s office is one potential source of help, especially if there is a pattern of problems with a particular insurance company.

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constructive feedback will help you improve your marketing materials and get better results.

- **Systematically track your referral sources.** Include professional referrals, advertisements and contacts that result from public speaking engagements, community involvement and other networking activities. During your initial contact with new clients, collect data about how they found out about you. This task can be as simple as adding one question to your intake form or just asking a new client when he or she calls to schedule the first appointment.

- **Periodically administer a client satisfaction survey.** Use the resulting data to identify areas in need of development and let clients know you are listening by addressing concerns, implementing realistic suggestions and communicating those changes in vehicles such as your practice newsletter, memos posted in your waiting room or a brief letter to your clients.

Every person with whom you interact is a potential client or referral source. Every document and communication from your practice is a marketing tool that can make or break a potential referral. By defining how you want others to perceive you and your practice and ensuring that your materials and the way you present yourself are consistent with that image, you can better reach those who could benefit from your services, help them make effective treatment decisions and drive business to your door.

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- **One more tip:** Psychologists in states with prompt payment laws may be able to use these laws to press insurance companies to pay claims within the required time. These laws typically require the company to pay within 30 days of receiving a “clean claim” that contains all the information a payer needs to process the claim.

_and a final important consideration:_ Consider who should deal with time-consuming insurance company interactions including submitting claims and handling denials. While some psychologists conduct these activities on their own, others hire support staff or engage an outside billing service. Using others to handle the administrative demands frees up the psychologist to devote more time to revenue-producing professional activities.

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**FOR MORE HELP**

The Reimbursement section of the Practice Central website at [apapracticecentral.org](http://apapracticecentral.org) provides additional guidance about claims submission and follow-up. Numerous articles on billing and coding for your services are accessible to members of the APA Practice Organization at [apapracticecentral.org/reimbursement/billing/index.aspx](http://apapracticecentral.org/reimbursement/billing/index.aspx).

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**IMPORTANT DEADLINE FOR MEDICARE PROVIDERS**

By December 31, 2010, all Medicare providers must enroll or verify enrollment information via the Medicare Provider Enrollment, Chain and Ownership System (PECOS). Failure to register with PECOS will result in the denial of Medicare claims as of January 1, 2011.

PECOS is an Internet-based system for mandatory Medicare provider enrollment that verifies providers have a valid National Provider Identifier (NPI). Providers who enrolled prior to 2003 or who have not updated their enrollment information since 2003 should verify their enrollment status to ensure that they are included.

In order to enroll, providers must have a web user account with the National Plan and Provider Enumeration System (NPPES) administered by the Centers for Medicare and Medicaid Services (CMS), and must have an established NPI. However, simply having an NPI does not guarantee that providers are enrolled.

After January 1, 2011, if a psychologist or a referring physician who is not enrolled in PECOS is listed on a Medicare claim, the claim will be denied.

The PECOS system and registration instructions can be accessed online through the secure Medicare enrollment site at [https://pecos.cms.hhs.gov/pecos/login.do](https://pecos.cms.hhs.gov/pecos/login.do).